



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

BAYLOR SURGICAL HOSPITAL  
750 13TH AVENUE  
FORT WORTH TX 76104

#### **Respondent Name**

LIBERTY MUTUAL FIRE INSURANCE

#### **Carrier's Austin Representative Box**

#01

#### **MFDR Tracking Number**

M4-10-0137-01

#### **MFDR Date Received**

SEPTEMBER 4, 2009

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Respondent did not pay the allowable 143% of MSDRG. In addition Respondent has not replied to our reconsideration request. Appeal Received 7/28/09, no response to date."

**Amount in Dispute:** \$7,496.35

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance/Division of Workers' Compensation Commission's Acts and Rules. We have received the medical dispute filed by Baylor Surgical Hospital for services rendered to...for the 05/06/2009 date of service. The bill and documentation attached to the medical dispute have been re-reviewed and our position remains unchanged...The provider has a PPO contractual agreement with Coventry PPO for workers compensation services...Liberty Mutual believes that Baylor Surgical Hospital has been appropriately reimbursed for services rendered..."

**Response Submitted by:** Liberty Mutual Insurance Group, 2875 Browns Bridge Road, Gainesville, GA 30504

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 6, 2009 Through May 8, 2009	Inpatient Hospital Surgical Services	\$7,496.35	\$7,496.01

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.4 sets out the guidelines for written notification to health care providers of contractual agreements for informal and voluntary networks
3. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for

inpatient services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 20, 2009

- 45 – Z547 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY REFLECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH YOUR PPO NETWORK CONTRACT AND OUR ACCESS AGREEMENT WITH THEM. (Z547)
- 42 – Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
- 42 – PA – FIRST HEALTH
- 24 – P303 – THIS SERVICE WAS REVIEWED IN ACCORDANCE WITH YOUR CONTRACT. (P303)

### **Issues**

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

### **Findings**

1. The insurance carrier reduced disputed services with reason code "45–Z547 – THIS BILL WAS REVIEWED IN ACCORDANCE WITH YOUR FEE FOR SERVICE CONTRACT WITH FIRST HEALTH. FOR QUESTIONS REGARDING THIS ANALYSIS PLEASE CALL (800) 937-6824. THIS REIMBURSEMENT MAY REFLECT PAYMENT AT RATES LESS THAN YOUR DISCOUNTED CONTRACT RATE IN ACCORDANCE WITH YOUR PPO NETWORK CONTRACT AND OUR ACCESS AGREEMENT WITH THEM. (Z547)." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 22, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.  
(1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:  
(A) 143 percent; unless  
(B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

3. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at <http://www.cms.gov>. Documentation found supports that the DRG assigned to the services in dispute is 858, and that the services were provided at Baylor Surgical Hospital of Fort Worth. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of \$7,461.91. This amount multiplied by 143% results in a MAR of \$10,670.57.
4. The division concludes that the total allowable reimbursement for the services in dispute is \$10,670.57. The respondent issued payment in the amount of \$3,174.56. Based upon the documentation submitted, additional reimbursement in the amount of \$7,496.01 is recommended.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$7,496.01.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$7,496.01 reimbursement for the disputed services.

### **Authorized Signature**

_____	<u>Greg Arendt</u>	<u>April 11, 2013</u>
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**